SmartSummary

Your personal medical benefits statement

Ronald Johnson
Jul 01, 2018 - Jul 31, 2018

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved) −	Plan's Share =	Your Share
Claim number 820181920382091- continued								
LAB CHEMISTRY, In-network; (301) 2	07/07/18	157.32	157.32	0.00		0.00	0.00	0.00
LAB CHEMISTRY, In-network; (301) 2	07/07/18	57.96	57.96	0.00		0.00	0.00	0.00
LAB HEMATOLOGY, In-network; (305) 2	07/07/18	30.36	30.36	0.00		0.00	0.00	0.00
RAD CHEST XRAY, In-network; (324) 2	07/07/18	294.40	234.95	0.00		59.45	59.45	0.00
EMER ROOM GENERAL, In-network; (450) 1, 2	07/07/18	1,319.29	979.04	0.00		340.25	260.25	80.00
RX REQ DET CODING, In-network; (636) 2	07/07/18	2.60	2.60	0.00		0.00	0.00	0.00
EKG/ECG GENERAL, In-network; (730) 2	07/07/18	234.26	234.26	0.00		0.00	0.00	0.00
	Totals:	2,105.64	1,705.94	0.00		399.70	319.70	80.00

1. You pay a $80.00 copayment for EMER ROOM GENERAL from an in-network provider.
2. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.

Claim number 820181910193459								
JENCARE SR MED CTR NORFOLK								
ESTAB. PT. 10 MIN. LIMIT/MINOR, In-network; (99212) 1, 2	07/02/18	56.00	0.00	11.86		44.14	35.31	0.00
MOST RECENT SYSTOLIC BLOOD PRESSURE 130-139 MM HG (DM) (HTN,CKD), In-network; (3075F) 1, 3	07/02/18				(See below.)			

Section 3 continued on next page

SmartSummary

Your personal medical benefits statement

Ronald Johnson
Jul 01, 2018 - Jul 31, 2018

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved) −	Plan's Share =	Your Share
Claim number 820181970126939								
CITY OF CHESAPEAKE E M S								
GROUND MILEAGE,PER STATUTE MILE, Out-of-network; (A0425) 1, 3, 4	07/07/18	18.00	0.00	4.73		13.27	10.62	2.65
AMB SERVICE,BASIC LIFE SUPPORT,EMERGENCY TRANSPORT (BLS,EMERGENCY), Out-of-network; (A0429) 2, 3, 4	07/07/18	470.00	0.00	106.82		363.18	290.54	72.64
	Totals:	488.00	0.00	111.55		376.45	301.16	75.29

1. You pay 20% of the total amount for GROUND MILEAGE,PER STATUTE MILE from an out-of-network provider.
2. You pay 20% of the total amount for AMB SERVICE,BASIC LIFE SUPPORT,EMERGENCY TRANSPORT (BLS,EMERGENCY) from an out-of-network provider.
3. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.
4. You may be responsible for paying some or all of the excluded charges to your provider.

Claim number 820181920333549								
SANJAY M PATEL MD								
RADIOLOGIC EXAM CHEST 2 VIEWS, Out-of-network; (71046) 1, 2	07/07/18	36.00	0.00	24.91		11.09	11.09	0.00
	Totals:	36.00	0.00	24.91		11.09	11.09	0.00

1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.
2. You may be responsible for paying some or all of the excluded charges to your provider.

Claim number 820181920382091								
CHESAPEAKE GENERAL HOSPITAL								
SUPPLIES GENERAL, In-network; (270) 2	07/07/18	9.45	9.45	0.00		0.00	0.00	0.00

Section 3 continued on next page

SmartSummary®
Your personal medical benefits statement

Ronald Johnson
Aug 01, 2018 - Aug 31, 2018

3 Section 3. Details for claims processed Aug 01, 2018 - Aug 31, 2018

Look over the information about your claims does it seem correct?

- If you have questions or think there might be a mistake, start by calling the doctor's office or other service provider. Ask them to explain the claim.
- If you still have questions, call us at Customer Care using the number on the back of your ID card or 1-800-733-3602 (TTY: 711).

You have the right to make an appeal or complaint.

- Making an appeal is a formal way of asking us to *change our decision* about your coverage. You can make an appeal if we deny a claim. You can also make an appeal if we approve a claim but you disagree with how much you are paying for the item or services. For information about making an appeal, call us at Customer Care using the number on the back of your ID card or 1-800-733-3602 (TTY: 711).

Remember, this report is NOT A BILL:

- If you have not already paid the amount shown for "your share," *wait until you get a bill* from the provider.
- If you get a bill that is *higher* than the amount shown for "your share," call us at Customer Care using the number on the back of your ID card or 1-800-733-3602 (TTY: 711).

What if you suspect Medicare fraud or dishonest billing?

- Most people and companies that provide Medicare health services, supplies, and equipment are honest. However, there are a few dishonest providers who charge Medicare on purpose for health care services, supplies, or equipment you didn't get.
- Fraud costs all of us millions of dollars every year. If you notice something suspicious that might be Medicare fraud, report it by calling us at Customer Care using the number on the back of your ID card or 1-800-733-3602 (TTY: 711). We are here 7 days a week, 8 a.m.- 8 p.m. Saturdays, Sundays and holidays your call may be handled by our automated phone system. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

To learn more about Medicare fraud and how to help prevent it, visit http://www.stopmedicarefraud.gov or http://www.smpresource.org.

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved) −	Plan's Share =	Your Share
Claim number 820182360146301								
EMILY A HAHN MD								
ER VISIT IMMED. LIFE THREATINGZ, Out-of-network; (99285) 1, 2	08/11/18	568.00	0.00	393.47		174.53	174.53	0.00
	Totals:	568.00	0.00	393.47		174.53	174.53	0.00

Section 3 continued on next page

SmartSummary®
Your personal medical benefits statement

Ronald Johnson
Aug 01, 2018 - Aug 31, 2018

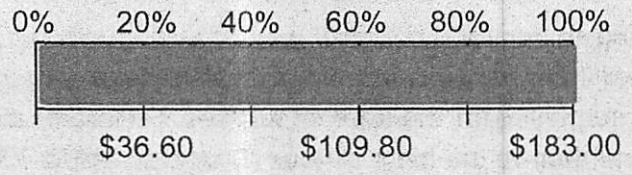
2 Section 2. Deductible and Yearly Limits

2018 Combined Part B Annual Deductible

In 2018, your plan deductible is $183.00.

For most covered services, the plan pays its share of the cost only after you have paid your yearly plan deductible.

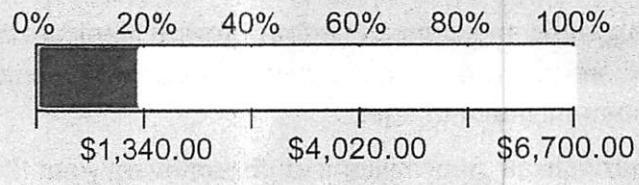
As of August 31, 2018, you have paid $183.00 toward your yearly plan deductible.



2018 Participating/In Network Out of Pocket

In 2018, $6,700.00 is the most you will have to pay for covered services.

As of August 31, 2018, you have had $1,243.07 in out-of-pocket costs that count toward your out-of-pocket maximum for covered services.



YEARLY LIMITS - these limits give you financial protection

These limits tell the most you will have to pay in 2018 in "out-of-pocket" costs (copays, coinsurance, and your deductible) for medical and hospital services covered by the plan.

These yearly limits are called your "out-of-pocket maximums." They put a limit on how much you have to pay, but they do not put a limit on how much care you can get. This means:

- Once you have reached a limit in out-of-pocket costs, you stop paying medical claims costs.
- You keep getting your medical and hospital services covered by the plan as usual, and the plan will pay the full cost for the rest of the year.

SmartSummary®

Your personal medical benefits statement

Ronald Johnson
Aug 01, 2018 - Aug 31, 2018

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved)	− Plan's Share	= Your Share
Claim number 820182190211155- continued								
DISCHARGE MEDICATIONS RECONCILED WITH THE CURRENT MEDICATION LIST, In-network; (1111F) 1, 3	07/31/18				(See below.)			
	Totals:	56.00	0.00	11.86		44.14	35.31	0.00

1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.
2. You may be responsible for paying some or all of the excluded charges to your provider.
3. The rate has been pre-negotiated by contractual arrangement with this provider.

! You currently receive one SmartSummary for your medical claims and one SmartSummaryRx for your Part D drugs. Beginning this fall, you will receive one SmartSummary that includes both medical claims and Part D drugs. All of the current information on the separate statements you receive today will be included in one new SmartSummary that is easier to read and understand.

Using in-network doctors may save you money. Humana negotiates rates with in-network doctors to help lower costs. You can see a list of in-network doctors by using the Physician Finder tool at Humana.com.

! Has your address or phone number changed? To make sure Humana is able to contact you about valuable plan information, it's important to let us know if you have changed your telephone number, mailing or residential address, even if it's just a temporary change. Please call the Customer Service number on the back of your Humana member identification card with any changes to your contact information.

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SmartSummary®

Your personal medical benefits statement

Ronald Johnson
Aug 01, 2018 - Aug 31, 2018

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved) −	Plan's Share =	Your Share
Claim number 820182270366883- continued								
RAD CHEST XRAY, In-network; (324) 2	08/11/18	294.40	234.95	0.00		59.45	59.45	0.00
EMER ROOM GENERAL, In-network; (450) 1, 2	08/11/18	477.30	358.01	0.00		119.29	39.29	80.00
RX REQ DET CODING, In-network; (636) 2	08/11/18	1.31	1.31	0.00		0.00	0.00	0.00
RX REQ DET CODING, In-network; (636) 2	08/11/18	13.96	13.96	0.00		0.00	0.00	0.00
	Totals:	1,251.75	890.13	0.00		361.62	281.62	80.00

1. You pay a $80.00 copayment for EMER ROOM GENERAL from an in-network provider.
2. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.

Claim number 820182190211155								
JENCARE SR MED CTR NORFOLK								
ESTAB. PT. 10 MIN. LIMIT/MINOR, In-network; (99212) 1, 2	07/31/18	56.00	0.00	11.86		44.14	35.31	0.00
MOST RECENT SYSTOLIC BLOOD PRESSURE LESS THAN 130 MM HG (DM) (HTN,CKD), In-network; (3074F) 1, 3	07/31/18				(See below.)			
MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 80 MM HG (HTN,CKD) (DM), In-network; (3078F) 1, 3	07/31/18				(See below.)			

Section 3 continued on next page

SmartSummaryRx®

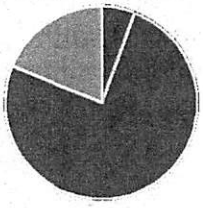
Your personal prescription benefits statement

This summary is your "Explanation of Benefits" (EOB) for your Medicare prescription drug coverage (Part D). Please review this summary and keep it for your records. THIS IS NOT A BILL.

Ronald Johnson
Member ID: H76034307
Plan name: Humana Value Plus H6622-045 (HMO) LIS
Rx PCN or Rx
Group Number: 03200000

Statement date: August 1-31, 2018

August prescription costs



Amount you paid	$3.70
Medicare subsidy	$48.94
Humana paid	$12.15
August prescription costs	$64.79

Your benefits summary

Stage 1

You pay:
- Preferred Generic drugs $1.25
- other drugs $3.70

The plan and Medicare pay the rest

You are in Stage 1. During this payment stage, the plan pays its share of the cost of your drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost.

Stage 2

You pay: $0.00

The plan and Medicare pay the rest

This summary includes: Sections 1 - 5

Contact us

If you have questions or need help, contact us free of charge.

Benefit questions
visit Humana.com or call 1-800-457-4708 (TTY 711)

Hours of operation
Monday - Sunday, 8 a.m. - 8 p.m. Saturdays, Sundays and holidays your call may be handled by our automated phone system

For large print or another format
To get this material in other formats, or ask for language translation services, call Humana Customer Care at the number on this page.

PDPBOOKPDP0027A09042018203900042 39N
RONALD JOHNSON
117 GATEWAY CT APT 209
CHESAPEAKE VA 23320-4594

Humana.

Y0040_GHHK3XREN

SmartSummaryRx®

Your personal prescription benefits statement

1 Section 1: Your prescriptions during the past month

Humana negotiates a reduced price with the pharmacy for its members, which is reflected in "Prescription cost with plan" column. The prescription cost can vary by pharmacy, location, quantity, strength and dosage of the medication. Adjusted claims may not be reflected in the table below; or if displayed, the amount paid may not be accurate because of the amount of the adjustment. THIS IS NOT A BILL. Keep this notice for your records.

Chart 1 - Your prescriptions for covered Part D drugs for August 2018

Chart 1 shows your prescriptions for covered Part D drugs for the past month. Please look over this information about your prescriptions to be sure it is correct. If you have any questions or think there is a mistake, see Section 4 (page 5), it tells you what to do.

Drug Name	Prescription cost with plan	Amount You paid	Other Payments (made by programs or organizations; see Section 2)	Amount Humana Paid	Extra Help from Medicare
Aug 14, 2018 | Jencare Rx Norfolk | Claim number# 186261331091					
Ventolin HFA 90 mcg/actuation aerosol inhaler 17 day supply Drug Category: Preferred Brand drugs	$52.64	$3.70	$0.00	$0.00	$48.94
Aug 17, 2018 | Walgreens #7886 | Claim number# 186298322931					
chlorhexidine gluconate 0.12 % mouthwash 16 day supply Drug Category: Preferred Generic drugs	$7.15	$0.00	$0.00	$7.15	$0.00
Aug 27, 2018 | Jencare Rx Norfolk | Claim number# 386393400721					
prednisone 20 mg tablet 5 day supply Drug Category: Preferred Generic drugs	$5.00	$0.00	$0.00	$5.00	$0.00

Section 1 Prescription claims continued on next page

HUM20151385101 0000000344 0002 0000 06

JenCare Senior Medical Center
A CHENMED COMPANY

549 E Brambleton Avenue
Norfolk, Virginia 23510
Phone: "757-533-9441" | Fax: "(757) 612-4353"
www. JenCareMed.com

August 27, 2018

To Whom it Concerns:

I am the primary care provider of Mr. Ronald Johnson who recently has been unc dermatitis (skin reaction) secondary to a chemical in the dish soap that is used by I previously provided a letter to his employer to ensure that he avoid exposure as recent exposure is causing his skin to itch severely and respond poorly to the pre medications given when I last saw him.

I am writing this second request to ask that he be accommodated with skin prote be exposed to the soap, he will need rubber gloves that preferably provide cover this not be provided, then I request that you accommodate him to perform othe maintain employment but avoid further exposure and irritation of his skin.

I am treating him for this condition in the office today and will have him stay out Should you have any other questions or concerns, please do not hesitate to cont consideration in this matter.

Kind Regards,

Lacia Chapman, MD

HUMANA
PO BOX 14163
LEXINGTON KY 40512-4163

00344

PDPBOOKPDP0027A090420182039000423 9N
RONALD JOHNSON
117 GATEWAY CT APT 209
CHESAPEAKE VA 23320-4594

Dear RONALD JOHNSON

Here is the reprint of the information you requested.
Please contact Humana for any further assistance.

Sincerely,

Humana

SmartSummary®

Your personal medical benefits statement

Ronald Johnson
Sep 01, 2018 - Sep 30, 2018

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved) −	Plan's Share =	Your Share
Claim number 820182560091208- continued								
1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.								
2. The rate has been pre-negotiated by contractual arrangement with this provider.								
Claim number 820182540447135								
JENCARE SR MED CTR NORFOLK								
ESTAB. PT. 10 MIN. LIMIT/MINOR, In-network; (99212) 1, 2	07/24/18	56.00	0.00	11.86		44.14	35.31	0.00
RADIOLOGIC EXAMINATION,FOOT ; 2 VIEWS, In-network; (73620) 1, 2	07/24/18	37.00	0.00	10.71		26.29	21.03	0.00
MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA), In-network; (1159F) 1, 3	07/24/18				(See below.)			
RVW MEDS BY RX/DR IN RCRD, In-network; (1160F) 1, 3	07/24/18				(See below.)			
Totals:		93.00	0.00	22.57		70.43	56.34	0.00
1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.								
2. You may be responsible for paying some or all of the excluded charges to your provider.								
3. The rate has been pre-negotiated by contractual arrangement with this provider.								
Claim number 820182480237063								
JENCARE SR MED CTR NORFOLK								
ESTAB. PT. 15 MIN LOW/MODERATE, In-network; (99213) 1, 2	08/27/18	93.00	0.00	19.59		73.41	58.73	0.00

Section 3 continued on next page

SmartSummary®

'our personal medical benefits statement

Ronald Johnson
Sep 01, 2018 - Sep 30, 2018

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved) −	Plan's Share =	Your Share
Claim number 820182480237063- continued								
MOST RECENT SYSTOLIC BLOOD PRESSURE LESS THAN 130 MM HG (DM) (HTN,CKD), In-network; (3074F) 1, 3	08/27/18				(See below.)			
MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 80 MM HG (HTN,CKD) (DM), In-network; (3078F) 1, 3	08/27/18				(See below.)			
DISCHARGE MEDICATIONS RECONCILED WITH THE CURRENT MEDICATION LIST, In-network; (1111F) 1, 3	08/27/18				(See below.)			
	Totals:	93.00	0.00	19.59		73.41	58.73	0.00

1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.
2. You may be responsible for paying some or all of the excluded charges to your provider.
3. The rate has been pre-negotiated by contractual arrangement with this provider.

You currently receive one SmartSummary for your medical claims and one SmartSummaryRx for your Part D drugs. Beginning this fall, you will receive one SmartSummary that includes both medical claims and Part D drugs. All of the current information on the separate statements you receive today will be included in one new SmartSummary that is easier to read and understand.

In April 2018, CMS will begin mailing Medicare beneficiaries new red, white and blue Medicare cards with a new unique number that does not include the Social Security Number. Medicare is taking this step to protect you from identity theft and fraud. It may be several months before you receive your new card. Once you receive it, destroy your old one. Remember, you will still use your Humana member ID card whenever you need care.

HUM2005138590I 000000411 0004 0006 18

Evidence
E F

HUMANA CLAIMS OFFICE
P.O. BOX 14603
LEXINGTON, KY 40512-4603

00413

MEDEOBEBPCE0101A08072018133300007905LV
RONALD JOHNSON
117 GATEWAY CT APT 209
CHESAPEAKE, VA 23320-4594

Dear RONALD JOHNSON

Here is the reprint of the information you requested.
Please contact Humana for any further assistance.

Sincerely,

Humana

SmartSummary®

Your personal medical benefits statement

Ronald Johnsc
Aug 01, 2018 - Aug 31, 201

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved)	− Plan's Share	= Your Share
Claim number 820182360146301- continued								
1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.								
2. You may be responsible for paying some or all of the excluded charges to your provider.								
Claim number 820182320030118								
LABORATORY CORP OF AMERICA								
TESTOSTERONE, TOTAL, In-network; (84403) 1, 2	08/15/18				(See below.)			
Totals:		155.00	155.00	0.00		155.00	0.00	0.00
1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.								
2. The rate has been pre-negotiated by contractual arrangement with this provider.								
Claim number 820182330284212								
JENCARE SR MED CTR NORFOLK								
ESTAB. PT. 15 MIN LOW/MODERATE, In-network; (99213) 1, 2	08/14/18	93.00	0.00	19.59		73.41	58.73	0.00
MOST RECENT SYSTOLIC BLOOD PRESSURE LESS THAN 130 MM HG (DM) (HTN,CKD), In-network; (3074F) 1, 3	08/14/18				(See below.)			
MOST RECENT DIASTOLIC BLOOD PRESSURE LESS THAN 80 MM HG (HTN,CKD) (DM), In-network; (3078F) 1, 3	08/14/18				(See below.)			

Section 3 continued on next page ➔

martSummary®

ur personal medical benefits statement

Ronald Johnson
Aug 01, 2018 - Aug 31, 2018

	Date of Service	Amount the provider billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan approved) −	Plan's Share =	Your Share
laim number 820182330284212- continued								
)ISCHARGE MEDICATIONS RECONCILED WITH THE CURRENT MEDICATION LIST, n-network; 1111F) 1, 3	08/14/18				(See below.)			
	Totals:	93.00	0.00	19.59		73.41	58.73	0.00

1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.
2. You may be responsible for paying some or all of the excluded charges to your provider.
3. The rate has been pre-negotiated by contractual arrangement with this provider.

Claim number 820182270323013								
)AVID M COHEN MD								
RADIOLOGIC EXAM CHEST 2 VIEWS, Out-of-network; (71046) 1, 2	08/11/18	36.00	0.00	24.91		11.09	11.09	0.00
	Totals:	36.00	0.00	24.91		11.09	11.09	0.00

1. EXPLANATION OF MEMBER RESPONSIBILITY The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, coinsurance, copayments, and non-covered services as outlined in your benefit plan document. It includes any amounts that the member may have previously paid to the provider of service. Also, any amounts denied for additional information may be re-evaluated.
2. You may be responsible for paying some or all of the excluded charges to your provider.

Claim number 820182270366883								
CHESAPEAKE GENERAL HOSPITAL								
PHAR IV THERAPY, In-network; (260) 2	08/11/18	197.06	14.18	0.00		182.88	182.88	0.00
LAB CHEMISTRY, In-network; (301) 2	08/11/18	125.12	125.12	0.00		0.00	0.00	0.00
LAB CHEMISTRY, In-network; (301) 2	08/11/18	80.04	80.04	0.00		0.00	0.00	0.00
LAB HEMATOLOGY, In-network; (305) 2	08/11/18	62.56	62.56	0.00		0.00	0.00	0.00

Section 3 continued on next page ➔

OTHER IMPORTANT AGREEMENTS

1. FINANCE CHARGE AND PAYMENTS

a. How we will figure Finance Charge. We will figure the Finance Charge on a daily basis at the Annual Percentage Rate on the unpaid part of the Amount Financed.

b. How we will apply payments. We may apply each payment to the earned and unpaid part of the Finance Charge, to the unpaid part of the Amount Financed and to other amounts you owe under this contract in any order we choose.

c. How late payments or early payments change what you must pay. We based the Finance Charge, Total of Payments, and Total Sale Price shown on page 1 of this contract on the assumption that you will make every payment on the day it is due. Your Finance Charge, Total of Payments, and Total Sale Price will be more if you pay late and less if you pay early. Changes may take the form of a larger or smaller final payment or, at our option, more or fewer payments of the same amount as your scheduled payment with a smaller final payment. We will send you a notice telling you about these changes before the final scheduled payment is due.

d. You may prepay. You may prepay all or part of the unpaid part of the Amount Financed at any time without penalty. If you do so, you must pay the earned and unpaid part of the Finance Charge and all other amounts due up to the date of your payment.

e. Your right to refinance a balloon payment. A balloon payment is any payment other than a down payment that is more than 10% greater than the regular or recurring installment payments. If you use the vehicle primarily for consumer purposes, you have the right to refinance a balloon payment over an extended period with additional payments. The additional periodic payments will not be more than 10% greater than the regularly scheduled installment payments.

2. YOUR OTHER PROMISES TO US

a. If the vehicle is damaged, destroyed, or missing. You agree to pay us all you owe under this contract even if the vehicle is damaged, destroyed, or missing.

b. Using the vehicle. You agree not to remove the vehicle from the U.S. or Canada, or to sell, rent, lease, or transfer any interest in the vehicle or this contract without our written permission. You agree not to expose the vehicle to misuse, seizure, confiscation, or involuntary transfer. If we pay any repair bills, storage bills, taxes, fines, or charges on the vehicle, you agree to repay the amount when we ask for it.

c. Security Interest.
You give us a security interest in:
- The vehicle and all parts or goods put on it;
- All money or goods received (proceeds) for the vehicle;
- All insurance, maintenance, service, or other contracts we finance for you; and
- All proceeds from insurance, maintenance, service, or other contracts we finance for you. This includes any refunds of premiums or charges from the contracts.

This secures payment of all you owe on this contract. It also secures your other agreements in this contract. You will make sure the title shows our security interest (lien) in the vehicle. You will not allow any other security interest to be placed on the title without our written permission.

d. Insurance you must have on the vehicle.
You agree to have physical damage insurance covering loss of or damage to the vehicle for the term of this contract. The insurance must cover our interest in the vehicle. If you do not have this insurance, we may, if we choose, buy physical damage insurance. If we decide to buy physical damage insurance, we may either buy insurance that covers your interest and our interest in the vehicle, or buy insurance that covers only our interest. If we buy either type of insurance, we will tell you which type and the charge you must pay. The charge will be the premium of the insurance and a finance charge computed at the Annual Percentage Rate shown on page 1 of this contract or, at our option, the highest rate the law permits.
If the vehicle is lost or damaged, you agree that we may use any insurance settlement to reduce what you owe or repair the vehicle.

e. What happens to returned insurance, maintenance, service, or other contract charges. If we obtain a refund of insurance, maintenance, service, or other contract charges, you agree that we may subtract the refund from what you owe.

3. IF YOU PAY LATE OR BREAK YOUR OTHER PROMISES

a. You may owe late charges. You will pay a late charge on each late payment as shown on page 1 of this contract. Acceptance of a late payment or late charge does not excuse your late payment or mean that you may keep making late payments.
If you pay late, we may also take the steps described below.

b. You may have to pay all you owe at once. If you break your promises (default), we may demand that you pay all you owe on this contract at once. Default means:
- You pay any payment (plus any late charges) more than 10 days late or not at all;
- You give us false, incomplete, or misleading information on a credit application;
- You start a proceeding in bankruptcy or one is started against you or your property; or
- You break any agreements in this contract.

The amount you will owe will be the unpaid part of the Amount Financed plus the earned and unpaid part of the Finance Charge, any late charges, and any amounts due because you defaulted.

c. You may have to pay collection costs. If we hire an attorney to collect what you owe, you will pay the attorney's fee and court costs as the law allows. You will also pay any collection costs we incur as the law allows.

d. We may take the vehicle from you. If you default, we may take (repossess) the vehicle from you if we do so peacefully and the law allows it. If your vehicle has an electronic tracking device, you agree that we may use the device to find the vehicle. If we take the vehicle, any accessories, equipment, and replacement parts will stay with the vehicle. If any personal items are in the vehicle, we may store them for you at your expense. If you do not ask for these items back, we may dispose of them as the law allows.

e. How you can get the vehicle back if we take it. If we repossess the vehicle, you may pay to get it back (redeem). We will tell you how much to pay to redeem. Your right to redeem ends when we sell the vehicle.

13:26:50 Tuesday, April 28, 2020

VLXV1 VIEW LEDGER 09999

ACCOUNT NUMBER . 90102408288450001_____ +
JOHNSON; RONALD
R N4 03 - - - - 0240000500 2PL A 03/09/2020
REFR: CLTR: D2SCI
AGCY: D2SCI 03/11/2020
START DATE _____

P: 12,672.07
O: 98.10
I: 1,539.45
C: 639.00
BAL: 14,948.62

DATE/REFR	TYPE	LEDGER 1 AFEE/TOTAL	INTR/PRIN	LAST PAGE COSTS/OINC
07/02/2019		.00	1,539.45	639.00
CHARGE OFF	C	16,849.37	14,572.82	98.10
10/08/2019		.00	.00	.00
CW B193917	R	1,900.75-	1,900.75-	.00
			1,539.45	639.00
TOT CHARGES	C	16,849.37	14,572.82	98.10
			.00	.00
TOT RECOVERIES	R	1,900.75-	1,900.75-	.00
			1,539.45	639.00
TOT BALANCES		14,948.62	12,672.07	98.10

END OF FILE.

COMMAND ===> ___
PF1=HELP PF3=EXIT PF4=PROMPT PF5=PREV PF6=NEXT PF8=FWD PF9=RETRV PF12=CANCEL

SmartSummary

Your personal medical benefits statement

Ronald Johnson
Aug 01, 2018 - Aug 31, 2018

1 Section 1. TOTALS for medical and hospital claims and Part B Pharmacy claims

	Amount providers have billed the plan	Plan Discounts	Benefit Exclusions	Other Insurance	Total Cost (amount the plan has approved) −	Plan's Share =	Your Share
Totals for this Month: Medical (for claims processed from August 1, 2018 to August 31, 2018)	2,159.75	1,045.13	449.83		819.79	561.28	80.00
Totals for this Month: Part B Pharmacy claims (for claims processed from August 1, 2018 to August 31, 2018)	0.00	0.00	0.00		0.00	0.00	0.00
Totals for 2018: Medical (for all dates of service from January 1, 2018 through August 31, 2018)	21,987.53	14,390.77	2,103.68		8,461.48	4,348.47	1,018.39
Totals for 2018: Part B Pharmacy claims (for all dates of service from January 1, 2018 through August 31, 2018)	0.00	0.00	0.00		0.00	0.00	0.00

SmartSummary®

Statement date:
Aug 01, 2018 - Aug 31, 2018

Humana.

MONTHLY REPORT
Medical and hospital claims processed
Aug 01, 2018 - Aug 31, 2018

For: Ronald Johnson

Member ID: H76034307
Plan: HMO
Group Name: HMO VIRGINIA

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

www.Humana.com

This is not a bill:

- This monthly report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. We send a separate report on Part D prescription drugs.
- If you notice something suspicious that might be dishonest billing, you can report it by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

This summary includes: Sections 1-3

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year.

Humana Customer Care

If you have questions, call the number on the back of your ID card or 1-800-733-3602 (TTY: 711). We are here 7 days a week, 8 a.m.- 8 p.m. Saturdays, Sundays and holidays your call may be handled by our automated phone system.

Humana
HUMANA CLAIMS OFFICE
P.O. BOX 14603
LEXINGTON, KY 40512-4603

MEDEOBEBPCE0102A090720181404000079 43LV

RONALD JOHNSON
117 GATEWAY CT APT 209
CHESAPEAKE, VA 23320-4594